STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445525	A. BUILDING **01 - MAIN BUILDING** B. WING _____	R **11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE AT THE TRACE	**8353 HIGHWAY 100** **NASHVILLE, TN 37221**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety revisit survey was conducted on 11/05/2018 for all previous deficiencies cited on 09/17/2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th day
11-3-18

PRINTED: 09/25/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#1	445525	A. BUILDING 01 - MAIN BUILDING B. WING _____	09/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE AT THE TRACE	8353 HIGHWAY 100 NASHVILLE, TN 37221

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 09/17/2018. During this Life Safety Survey, NHC Place at the Trace was found not in substantial compliance with the requirements for participation in Medicare/Medicaid with Title 42 CFR Subpart 483.70(a), The Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-06 Standards For Nursing Homes, and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).	K 000		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to comply with the general requirements. The findings included: 1. Observation on 09/17/2018 at 10:34 AM, revealed the 1 1/2 hour Nursing Home/ Assisted Living separation cross corridor fire doors at the dietary director's office did not latch within the frame. NFPA 101, 19.1.3.1 (2012 Edition) NFPA 101, 6.1.14.4.1 (2012 Edition) NFPA 101, 8.3.3.1	K 100	Please see attached Plan of Correction	10/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Pat Pa | Administrator | 10/3/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

received
10-4-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445525	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE AT THE TRACE	**8353 HIGHWAY 100 NASHVILLE, TN 37221**

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K 100	Continued From page 1 (2012 Edition) NFPA 80, 6.1.4.2.1 (2010 Edition) 2. Observation on 09/17/2018 at 11:21 AM, revealed the 1 1/2 hour Nursing Home/ Assisted Living separation cross corridor fire doors at the lobby did not latch within the frame and the fire pin was damaged. NFPA 101, 19.1.3.1 (2012 Edition) NFPA 101, 6.1.14.4.1 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 6.1.4.2.1 (2010 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 09/17/2018.	K 100		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321	Please see attached Plan of Correction	10/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445525	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE AT THE TRACE	**8353 HIGHWAY 100 NASHVILLE, TN 37221**

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K 321	Continued From page 2 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to protect the hazardous areas. The findings include: Observation on 09/17/2018 at 10:44 AM, revealed the kitchen dry storage room door was held open with a magnet. NFPA 101, 19.3.2.1.3 (2012 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 09/17/2018.	K 321		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing	K 923	Please see attached Plan of Correction.	10/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445525	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**09/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC PLACE AT THE TRACE	**8353 HIGHWAY 100 NASHVILLE, TN 37221**

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K 923	Continued From page 3 gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to protect Gas Equipment - Cylinder and Container Storage. The findings include: Observation on 09/17/2018 at 12:54 PM, revealed 53 "E" sized oxygen cylinders stored in the 2nd floor storage room by elevator #5 within 5 feet of combustible materials (wood cabinet and wheelchairs). NFPA 99, 11.3.2.3 (2012 Edition)	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 923	Continued From page 4 Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 09/17/2018.	K 923		

Plan of Correction: K 100 – General Requirements - Other

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The latch on the 1 ½ hour Nursing Home/ Assisted Living separation cross corridor fire doors have been adjusted. The door is closing and latching properly.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All fire doors were checked to ensure they were latching and closing properly.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?

All fire doors will be checked monthly to ensure they are closing and latching properly.

How the corrective action will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?

Maintenance supervisor and/or designee will report findings from monthly fire door checks to Quality Assurance committee at monthly QA meeting for 3 months.

Completion Date: 10/01/18

HPH

Plan of Correction: K 100 – General Requirements - Other

2. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The 1 ½ hour Nursing Home/ Assisted separation cross corridor fire doors at the lobby have been adjusted to latch properly and the fire pin has been replaced.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All fire doors were checked to ensure they were latching and closing properly.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?

All fire doors will be checked monthly to ensure they are closing and latching properly.

How the corrective action will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?

Maintenance supervisor and/or designee will report findings from monthly fire door checks to Quality Assurance committee at monthly QA meeting for 3 months.

Completion Date: 10/01/18

HAH

Plan of Correction: K 321 - Hazardous Areas – Enclosure

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The magnet has been removed from the kitchen dry storage room door to ensure the door always remains closed.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

100% audit was done on all doors that enclose hazardous areas.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?

Maintenance staff was in-serviced on 9/19/18 on correct door enclosures in hazardous areas.

How the corrective action will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?

Maintenance supervisor and/or designee will monitor all doors that enclose hazardous areas with monthly checks to ensure these doors always remain closed and are not held open with magnets. Findings will be reported to the Quality Assurance committee at monthly QA meeting for 3 months.

Completion Date: 10/01/18

Plan of Correction: K 923 – Gas Equipment-Cylinder and Container Storage

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

All "E" sized oxygen cylinders stored in the 2nd floor storage room by elevator #5 will be moved to new oxygen storage room on Station 1 next to soiled linen room where there will be no combustible materials next to "E" sized oxygen cylinders within 5 feet.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Maintenance staff will ensure no "E" sized oxygen cylinders will be stored in any storage room except for the new designated oxygen storage room on Station 1 next to soiled linen room.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?

Maintenance, housekeeping, and nursing staff will be in-serviced on proper "E" sized oxygen storage procedures to not be within 5 feet of combustible materials by 10/05/18.

How the corrective action will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?

Maintenance will continue monitoring all storage rooms to ensure no "E" sized oxygen cylinders are stored near combustible materials.

Completion Date: 10/12/18

HHH